CONSENT & AGREEMENT

Date ___________________________

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Your Name

We are embarking on a journey to a better, healthier you. I want to be sure that we understand how this will work, and that you are comfortable with the process. In that regard, please confirm your agreement with the following by signing your name at the end of this document:

1. I need some personal information such as your age, medical history, medications and nutritional supplements you may be taking, among other details about you to complete my nutritional assessment today and to design a personal nutrition care plan for you.

2. Your personal nutrition care plan may include specific recommendations to change the type of food choices (foods & beverages) you may be making, the quantity being consumed, and/or when the food choices are being consumed.

3. Your personal nutrition care plan may require you to complete various activities such as keeping a daily food record or diary.

4. Your height, weight, and waist circumference may need to be recorded as part of completing my nutrition assessment. In recording these, I may be required to touch you to take your height, weight, and measure your waist with a tape measure.

5. I will keep your personal information secured in accordance with provincial laws (College of Dietitians of Ontario) and will use it only for the purpose of your personal nutrition care plan and communicating with your health care providers (with your consent) or in the case of emergency or as may be required by law.

6. I will keep your file on record for ten (10) years after our last meeting in accordance with provincial laws (College of Dietitians of Ontario).

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7. Your file will be kept active for three (3) months from the time of our last meeting. Any sessions that are not used in three months after the last meeting will become null and void.

8. Fees for any remaining pre-paid sessions will be forfeited if there is more than a three (3) month lapse between meetings.

9. If you choose not to complete the program that you have signed up for, there will be no refunds and sessions can not be transferred to family members or friends.

10. Please provide 24 hours' notice for any cancellation or change of appointment time. A $30 fee will apply if notice of 24 hours' notice is not provided. There will be no exceptions.

11. By communicating with me via email or text or other platform (ie. Private messenger on Facebook), you accept the inherent risk that your information (name, email address, or other information exchanged via these internet-based communication channels) is not 100% secure. Every effort is made to ensure your information is kept secure however there is a potential risk it may not be.

By Signing Below, You Understand & Agree with the Above Statements:

I have read, or have had read to me, all of the above and understand the information provided by you. I have had the opportunity to ask questions about your services, nutrition care plans, as well as any personal information that you may record about me. I understand that you may confer with my physician about my nutrition care plan and may obtain information from my physician in relation to the same. I also confirm that your advice and counselling do not over-ride my physician's advice and that you may rely on information provided by my physician.

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Signature of Client

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Name and Signature of Registered Dietitian (Witness)